4/7/2010

Question: If only Part A & Part B therapy minutes and days are reported – How do Medicaid reimbursement systems utilize the rehab section when not combined with a Medicare stay?

Answer: Skilled therapy is coded, regardless of payer. However, for Part A & B there are specific definitions for mode of therapy. State agencies should determine which definitions their providers follow for Medicaid only residents.

Question: May we have a copy of the therapy worksheet instructions? With all the calculations for training?

Answer: The example was taken directly from the manual, see pages O-19 to O-22.

Question: Measuring 30 day discharge interval. Is the discharge date day 1 on the first full day after discharge? Discharge date 10/15. Does 30 day count start 10/15 or 10/16?

Answer: Yes, in this example day 1= 10/16.

Non-Part A/Part B/Therapy

Question: Regarding Physical Therapy, Occupational Therapy, and Speech Language Pathology, can Section O be used for non-PPS assessments?

Used for state case-mix/OBRA assessment?

Answer: In order to code therapies in Section O, they must meet the definition of skilled therapy

Recreation Therapy

Question: What is the difference between recreational therapy and activities?

Answer: These terms are defined in Appendix A, page A-29.

Cognition

Question: Does the Brief Interview for Mental Status (BIMS) replace the Mental Status Questionnaire in MDS 3.0?

Answer: No, the Brief Interview for Mental Status (BIMS) replaces the Cognitive Performance Scale. CMS does not use the Mental Status Questionnaire (MSQ).

Section D

Question: Please define: PHQ-9© and PHQ9-OV©

Answer: PHQ-9© = Patient Health Questionnaire

PHQ-9 OV©= Patient Health Questionnaire Observation

Definition is in the manual on page D-3.

Behavior Section E

Question: E0800 (Rejection of Care – Presence & Frequency) – If resident consistently refuses meds (Rx), the interdisciplinary team (IDT) has discussed, and family aware to no avail – code as a dash? Or "0" or "9"

Answer: Directions are to exclude behaviors that have already been addressed, so answer to E0800 would be coded as 0, behavior not exhibited.

Section G

Question: Since the MDS is not a free standing document and is a data set, would it be fair to say that the surveyors should expect to see documentation in the resident chart of the activities of daily living (ADLs) with repeat to rules of 3 or any other element of MDS?

Answer: CMS does not impose specific documentation procedures on providers in completing the RAI. Documentation that contributes to identification and communication of a resident's problems, needs, and strengths that monitors his/her condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained licensed health care professionals. Good clinical practice is an expectation of CMS.

Question: Regarding G0110 (Activities of Daily Living (ADL) Assistance) "talk with direct care staff from each shift that has cared for the resident," many facilities utilize a data collection form for staff from all shifts to utilize during the observation period. Can this take the place of the staff interviews?

Answer: The expectation is a direct conversation with a staff member. Providers should develop their own processes to ensure that this expectation is met.

Section I

Question: If the facility does a recapitulation of physician's orders every 30 days AND there is a diagnosis listed with each med AND there is a diagnosis list on the order sheet(s) AND it is within the look back period – would these diagnoses be marked in Section I?

Answer: Refer to Section I of the MDS 3.0 manual, pages I-3 through I-9 for specific steps and requirements that need to be met for coding diagnoses.

Section J

Question: If (for example), the MDS is coded that the resident has had "constant" pain in the last 5 days, but has not told staff, when doing a review of the chart, this coding is not supported in the documentation that could appear as "miscoded". Please advise how to approach this situation.

Seems like with the 3.0, a lot of information could come out in all the interview techniques that are unsupported in documentation. Nurses are taught- "if it's not documented, it wasn't done."

Answer: The MDS would be coded as appropriate with the information gleaned from the resident even if the staff feels differently about the resident's response. However, the resident's medical record should accurately reflect the resident's response, the staff's assessment, and what action the nursing home has taken based on the response and/or assessment.

Section K

Question: Section K – Where did the chewing problem go?

Answer: Section L, Oral/Dental Status, Item L0200F, (Mouth or facial pain, discomfort or difficulty with chewing).

Section K has separate swallowing item, K0100 (Swallowing/Nutritional Status - Swallowing Disorder).

Question: 1) Facilities are asking why tube feedings are not therapeutic diets; 2) they are also being told by consultants to code mechanically altered diet as therapeutic diets saying they are still therapeutic diets when mechanically altered is ordered but not coded. 3) When is a tube feeding therapeutic and when is a mechanically altered therapeutic?

Answer: Enteral feeding and mechanically altered diet should only be coded as therapeutic diets when they meet the definition of therapeutic diets. Enteral feedings are not mechanically altered diets. See definitions on page K-9 of the MDS 3.0 manual.

Section K – Height

Question: If the resident is a bilateral amputee, how should the resident's height be measured? What is the acceptable standard?

Answer: CMS does not impose specific clinical methods or documentation procedures in completing the RAI. Identifying acceptable evidence-based or standardized clinical methods are a matter of good ongoing clinical practice of any nursing facility and an expectation of trained licensed health care professionals. Good clinical practice is an expectation of CMS.

Nutritional/Hydration M1200D

Question: Are vitamins and supplements still included in this section?

Answer: Yes, see definition "Nutrition or Hydration Intervention to Manage Skin Problems" on page M-31.

ADL

Question: Activity occurred only one time during the observation period. The single occurrence was 4 – total dependence. Is that coded as a 4 – on the MDS?

Answer: No. Code '7' – activity occurred only once or twice

Section O – Tracheostomy care O0100E

Question: The manual says to code cleansing of the trach and/or cannula – what if the resident does this care themselves?

Answer: Yes, you can code tracheostomy care in item O0100E if the resident performs this care for themselves.

Swing Bed

Question: Please review the MDS 3.0 required sections for swing beds quarterly assessments.

Answer: Under Medicare requirements, swing beds are not required to complete quarterly assessments.

Restorative Nursing Program

Question: If the MDS is blank for restorative nursing yet the facility says that the resident receives ROM or is on the floor ambulation program, should the MDS coding be assessed as inaccurate?

Answer: In order for restorative nursing care to be coded on the MDS, the requirements under "Steps for Assessment" on page O-23 must be met. If the requirements for restorative nursing care on page O-23 are not met, then the MDS would not be coded.

Section O O0100H-IV Meds

Question: What other items can possibly be coded here when they are not pumps? How about an epidural injection for back/pain problems?

Answer: Single intrathecal injections are not coded in this item, it is only coded here if managed on a pump.

General Question

Question: Do you have recommendations on preferences as to what discipline assesses any particular section of MDS?

Answer: CMS requires that the assessment accurately reflects the resident's status, a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals, and the assessment process includes direct observation, communication with the resident and direct care staff on all shifts. Please refer to the MDS 3.0 manual Chapter 1, section 1.3, "Completion of the RAI" for more information.

Survey Discharge Assessment

Question: The regulations at F283 and 284 address discharge summaries – was the discharge assessment designed to meet this requirement?

Answer: No. The discharge assessment is not designed to meet the requirements at F283 and 284. The MDS was designed to be part of the process.

Brief Interview for Mental Status (BIMS)/PHQ-9©

Question: Must the Brief Interview for Mental Status (BIMS) or PHQ-9 be completed in the same sitting if the resident becomes agitated and doesn't want to answer "anymore of these questions" but you are still within the Assessment Reference Date (ARD) can you attempt to complete when in a better mood?

Answer: CMS does not require that all interview items be completed at the same time. Providers must determine the best timing and process for each individual resident as long as the requirements for each item are met.

NH Quarterly MDS form

Question: Quarterly MDS on website – is the Quarterly MDS "subset" form actively 33 pages and include all comprehensive items?

Answer: The Quarterly item set is a subset of the Comprehensive item set. Not all items are 'active' on the Quarterly item set due to resident status and incorporation of many more skip patterns compared to MDS 2.0. For example, in most instances, either the resident interview or the staff interview items will be completed, but not both.

Pain Assessment Interview

Question: If the resident answers "no" to having pain, yet has received "as needed" (PRN) pain medication in the last 5 days, will it trigger a Care Area Assessment (CAA) for pain in order to clarify that the resident may have answered no but the Medication Administration Record (MAR) reveals pain is evident and should be further addressed? It doesn't appear that J0100B (Received PRN pain medications) or J0100C (Received non-medication intervention for pain) triggers.

Answer: Whether or not any MDS items trigger a CAA, facilities should still care plan problems that exist for the resident.

C0400 (Recall)

Question: Interview clip – saying that same questions maybe "more difficult" to me would increase marginally cognitively impaired resident's anxiety of failing to answer it right.

Answer: The interviewer can choose language similar to "more difficult" as long as the intent of the question is not changed and is understood by the resident. Facilities need to determine what terminology is best for that resident at the time of the interview.

Care Area Assessments (CAAs) and Care Planning

Question: This section discusses care planning resident problems. But if the goal is to preserve current status, or highest practicable status, shouldn't strengths be included, if it is to be individualized?

Answer: This is addressed in the MDS 3.0 manual, Chapter 4, pages 4-10 through 4-13. The text lists elements that may be included (but not limited to) strengths, needs, problems, etc.

Section V

Question: Will CMS set a timeframe for current evidence based/expert, based tasks? When I was in the military our references could be no older than 5 years. Like samples that were given during discussions, facilities may use outdated resources or not keep up to date.

Answer: CMS is not being prescriptive regarding this to allow facilities the flexibility. Facilities will need to use clinical judgment, with input from the interdisciplinary team (IDT), related to current standards of care. This also gives the facility the opportunity for greater input from their medical director.

All interviews

Question: One speaker said not to code answers in front of residents but all videos showed nurse with clip board and forms and was coding while with resident. What is best? Could it be intimidating to resident to see a person writing?

Answer: Providers and clinicians should determine what process is best for each individual resident.

Interviews

Question: Should we encourage facilities to do all the interviews at the same time as demonstrated? Brief Interview for Mental Status (BIMS) then CAM©, PHQ-9© then pain or does it matter except that CAM© is to follow BIMS?

Answer: CMS does not require that all interview items be completed at the same time. Providers must determine the best process for each individual resident as long as the requirements for each item are met.

A0310E (Type of Assessment – Is this assessment the first assessment (OBRA or PPS) since the most recent admission)

Question: "Is this assessment the first assessment since the most recent admission?" Does this mean:

1. Is this the admission assessment, or
2. Is this the first assessment since the most recent admission,
3. Other?

Answer: It means, is the current assessment the first assessment since the most recent admission or reentry.

Scheduling – Chapter 2

Question: Is it ARD + 92 days (or 93 days) OR ARD + 91 days (92 days)?
Next day=day 1

Answer: ARD + 92 days

Assessment Reference Date (ARD)

Question: I believe some of the confusion over ARD and completion comes from ARD being the end of the observation period not the date these items are coded. Is there a time frame when the dataset items must be coded if the ARD date is the end of the observation period?

Answer: Yes, there are specific time frames for when the assessment must be completed. Refer to table in the MDS 3.0 manual, Chapter 2, pages 2-12 and 2-13 "RAI OBRA-Required Assessment Summary." The assessment type impacts the completion date requirement.

Question: If ARD is day 14, the facility is still observing the resident until midnight on day 14, and would not be able to complete MDS until day 15, 1 day late. Has this changed? If so, what am I now supposed to tell my providers?

The concept of the ARD being the last day (ending at midnight) of the observation period is outlined in Chap 2 of the manual, on page 2-11 it states "in other words, if it did not occur during the look back period, it is not coded on the MDS." Will all this be deleted? How can we possibly sell this to providers when it makes no sense?

Answer: For the OBRA Admission assessment, regulations require that the provider must complete the assessment by the 14th day of the stay. This does not preclude a provider from choosing the 14th day as the ARD, even though the entire day should be included to complete the assessment.

Question: Is there anything in Chapter 3 (I didn't find) that says they can't count the first day as the ARD and then count things from inpatient stay?

Answer: No, those completing the assessment have to look at each individual item to determine whether the coding allows for including information prior to admission.

ARD – Z0400 (Assessment Administration – Signature of Persons Completing the Assessment)

Question: Should the date of the ARD be the same date the person assents to the accuracy of the questions?

Answer: Z0400 is the date the item is completed and the person completing it attests to its accuracy. For most items, the resident must be observed throughout the entire look-back period, which ends at the end of the ARD, and Z0400 would be after the ARD. Other items may be point-in-time observations, such as weight measurement, which may be completed on any day in the look-back period. Providers should complete items and date Z0400 based on the requirements for the particular item.

Payment Source

Question: MDS 2.0 identifies a pay source – Medicare, Medicaid, HMO, Private insurance, etc. Does 3.0 ask for this information? Are there plans to add this to 3.0?

Answer: No, based on studies these items were found to be inaccurately coded. CMS has no plans to include these items in the MDS 3.0.

Pain

Question: Pain assessment does not include validated tool for cognitively impaired or non-verbal residents…will that be added?

Answer: According to studies, most residents even those cognitively impaired can respond to interview items including pain. Non-verbal residents may also be able to communicate responses to interview items. The Staff Assessment for Pain, Item J0800 does incorporate assessment items that can be used for non-verbal or cognitively impaired residents. See page J-16 in the MDS 3.0 manual for further information.

Restraints

Question:

1. Why are chair alarms not listed on example of restraints and where would they be coded in what category?

2. Who determines if a resident has a true medical symptom?

Answer:

1. Chair alarms like any device, material, equipment, or physical or manual method, has to be assessed related to the effect it has on the resident. See Chapter 3, page P-1 in the MDS 3.0 manual for further information. If the device meets the definition of a physical restraint for a particular resident, the provider must code that device as a restraint.

2. The physician determines what medical symptom he is treating, and has to write the order.

MDS 2.0

Question: Will there be a cutoff date when a facility will no longer be able to submit an MDS assessment or correction?

Answer: Assessments with ARD of 09/30/2010 must be an MDS 2.0. Assessments with an ARD of 10/01/2010 must be an MDS 3.0. CMS has not determined the cut-off date for when an MDS 2.0 record may not be modified or inactivated.

MDS completion and RN Care assessment Coordinator Role

Question: There are many facilities who utilize LPNs to complete MDS and care plan and the RN (usually a DON) just signs the MDS. What is the federal expectation of the "RN assessment

coordinator"? And, any recommendations for LPNs to not be involved in entire process, especially assessment components, which may be outside their scope of practice. Some sections like M appear to require RN as wounds are assessed.

Answer: CMS requires that an RN conducts or coordinates each assessment with the appropriate participation of health professionals. However, nursing homes determine who should participate in the assessment process, how the assessment process is completed, and how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and within State practice act requirements.

E1100

Question: When determining a change, the instructor specified to "use clinical judgment." Would an LPN (who generally completes the MDS' in our state) be acceptable to do this, or is it expected an RN would be doing this?

Answer: CMS requires that an RN conducts or coordinates each assessment with the appropriate participation of health professionals. However, nursing homes determine who should participate in the assessment process, how the assessment process is completed, and how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and within State practice act requirements.

A1100

Question: If resident requests an interpreter to communicate with physician or health care staff, does that obligate facility to provide interpreter and if so, can family member (non-medical) act as interpreter?

Answer: Yes, facilities are obligated to provide a qualified interpreter as referenced in the Americans with Disabilities Act (ADA). Title III of the ADA contains provisions for auxiliary aids and services. "A public accommodation shall take those steps that may be necessary to ensure that **no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services**, unless […] [there is evidence] that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, i.e. significant difficulty or expense." **28 C.F.R. §36.303**. The term **auxiliary aids is further defined to include "qualified interpreters**, note takers, computer-aided transcription services, written materials..."